



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

KEVIN A. WILLIAMS, MD

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-17-1781-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

FEBRUARY 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$345.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 99212-25 was denied as included in the procedures/diagnostic testing. NO significant separately identifiable Evaluation and Management Service has been documented....CPT code J1040...was denied with Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge...CPT code J2001...is included in the value of the surgery procedure."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2016	CPT Code 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	\$220.00	\$7.87
	CPT Code 99212-25 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	\$75.00	\$0.00

	HCPCS Code J1040 Injection, methylprednisolone acetate, 80 mg	\$35.00	\$0.00
	HCPCS Code J2001 Injection, lidocaine HCl for intravenous infusion, 10 mg	\$15.00	\$0.00
TOTAL		\$345.00	\$7.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
- The services in dispute were reduced/denied by the respondent with the following reason code:
 - P300-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - P303-This service was reviewed in accordance with your contract.
 - PNFC-The reimbursement is based on the CMS physician fee schedule non-facility site of service rate.
 - X006-Local infiltration, digital block or topical anesthesia is included in the value of the surgery procedure.
 - X212-This procedure is included in another procedure performed on this date.
 - X358-Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.

Issues

- Does a contractual agreement issue exist in this dispute?
- Is the requestor entitled to additional reimbursement for code 20610?
- Does the documentation support billing 99212-25? Is the requestor entitled to reimbursement?
- Does the documentation support billing HCPCS code J1040? Is the requestor entitled to reimbursement?
- Is the allowance of code J2001 included in the allowance of code 20610? Is the requestor entitled to reimbursement?

Findings

- According to the submitted explanation of benefits, the respondent reduced payment for code 20610-RT based upon a contractual agreement. A review of the submitted documentation finds that neither party to the dispute submitted any information to support a contractual agreement exists; therefore, the disputed services will be reviewed per applicable division rules and fee guidelines.
- The disputed issue is whether the requestor is due additional reimbursement per 28 Texas Administrative Code §134.203 for code 20610-RT.

On the disputed date of service the requestor billed codes 20610-RT, 99212-25, J1040 and J2001.

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers..."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 71.32.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75234, which is located in Dallas, Texas; therefore, the Medicare participating amount is based on locality "Dallas, Texas".

The Medicare participating amount for code 20610 is \$46.92

Therefore using the above formula, the Division finds the MAR is \$93.46. The respondent paid \$85.59. The requestor is due the difference of \$7.87.

3. The respondent denied reimbursement for the office visit, CPT code 99212-25 based upon the service is included in code 20610.

Per CCI edits, code 99212 is included in code 20610; however a modifier is allowed to identify a separate evaluation and management service. The requestor appended modifier "25- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

A review of the submitted Progress Note does not support that the patient's condition required a significant, separately identifiable E/M service above and beyond the care associated with code 20610. In addition, the documentation does not support the key components required for billing code 99212. As a result, reimbursement is not recommended.

4. The respondent denied reimbursement for code J1040 based upon a lack of documentation to substantiate the charge.

A review of the submitted report does not support billing HCPCS code J1040. As a result, no reimbursement is recommended.

5. The requestor is seeking reimbursement for HCPCS code J2001 that was denied reimbursement based upon the service is included in code 20610.

Per CCI edits, code J2001 is included in code 20610; however, a modifier is allowed to differentiate the service. A review of the submitted bill finds that the requestor did not use a modifier to differentiate the service; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$7.87.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$7.87, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	<u>2/23/2017</u> Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.